BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of Rules I through XI, the amendment of ARM 37.104.101, 37.104.105, 37.104.106, 37.104.201, 37.104.203, 37.104.208, 37.104.212, 37.104.213, 37.104.218, 37.104.221, 37.104.306, 37.104.307, 37.104.311, 37.104.312, 37.104.316, 37.104.319, 37.104.329, 37.104.336, 37.104.401, 37.104.404, 37.104.616 and 37.104.805 and the repeal of ARM 37.104.219, 37.104.220, 37.104.317, 37.104.318, 37.104.327, 37.104.328, 37.104.402 and 37.104.403 pertaining to emergency medical services	)	NOTICE OF ADOPTION, AMENDMENT AND REPEAL

TO: All Interested Persons

1. On July 14, 2005, the Department of Public Health and Human Services published MAR Notice No. 37-352 pertaining to the public hearing on the proposed adoption, amendment, and repeal of the above-stated rules relating to emergency medical services, at page 1238 of the 2005 Montana Administrative Register, issue number 13.

2. The Department has adopted new rules I (37.104.204), II (37.104.109), III (37.104.111), IV (37.104.205), V (37.104.206), VI (37.104.114), VII (37.104.108), X (37.104.110), and XI (37.104.320) as proposed.

3. The Department has amended ARM 37.104.105, 37.104.106, 37.104.201, 37.104.208, 37.104.213, 37.104.218, 37.104.306, 37.104.307, 37.104.311, 37.104.312, 37.104.319, 37.104.329, 37.104.336, 37.104.401, 37.104.404, 37.104.616 and 37.104.805 and repealed ARM 37.104.219, 37.104.220, 37.104.317, 37.104.318, 37.104.327, 37.104.328, 37.104.402, and 37.104.403 as proposed.

4. The Department has adopted the following rules as proposed but with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

RULE VIII [37.104.112] STANDARD OF CARE (1) All emergency medical personnel must provide care which conforms to the general standard of care ~~expected of persons who are~~

~~comparably trained, certified or licensed~~ promulgated by the board of medical examiners.

AUTH: 50-6-323, MCA
IMP: 50-6-323, MCA

RULE IX [37.104.330] EMT LEVEL OF CARE LIMITATIONS

(1) With the exception of a physician or the circumstances described in ARM 37.104.335(3), ~~no attempt may be made by~~ individual personnel ~~to~~ shall not provide a level of care higher than the level and type for which the emergency medical service is licensed~~, even though individual members of the emergency medical services may have a higher level of certification~~. The service must be licensed or authorized to operate at the highest level it plans to allow individuals to provide care.

~~(2) An EMT licensed or endorsed beyond the EMT-B level may perform acts allowed under the EMT's licensure level or endorsement level only when authorized under the service license.~~

AUTH: 50-6-323, MCA
IMP: 50-6-323, MCA

5. The Department has amended the following rules as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

37.104.101 DEFINITIONS The following definitions apply in subchapters 1 through 4.

(1) through (5) remain as proposed.

~~(6) "Authorization" means department approval of an ambulance service or nontransporting medical unit (NTU) to provide advanced life support on a less than 24 hours per day, seven day per week basis due to limited personnel.~~

(6) "Authorization" means the authorization for an ambulance service or nontransporting medical unit to provide limited advanced life support as provided in ARM 37.104.109.

(7) through (11) remain as proposed.

~~(12) "Defibrillator with dual channel recording capabilities" means a device, approved by the department, capable of continuously recording the electrocardiogram and simultaneously recording the events at the scene, and shall be portable, self-contained, DC powered, and capable of defibrillation according to the defibrillation protocol, either manually, semi-automatically or automatically.~~

(13) through (21) remain as proposed but are renumbered (12) through (20).

~~(22) "First responder-ambulance" means an individual licensed by the board as an EMT-F with an ambulance endorsement as listed in ARM 24.156.2751.~~

(23) through (37) remain as proposed but are renumbered (22) through (36).

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.203 EQUIPMENT (1) remains as proposed.

(2) When ~~table I in (6) shows that~~ a transportation equipment kit or safety and extrication kit is required, it must be physically in each ground ambulance at all times and available to each air ambulance on every call.

(3) remains as proposed.

~~(4) Table I in (6) shows the equipment kit which is required for licensure at each of the various types and levels of emergency medical services.~~

~~(5) For the purpose of Table I in (6), the following terms apply:~~

~~(a) basic means basic equipment kit;~~

~~(b) transport means transportation equipment kit;~~

~~(c) safety means safety and extrication kit; and~~

~~(d) ALS means advanced life support kit.~~

~~(6) TABLE I~~
~~Equipment kit~~

	~~Basic~~	~~Trans-port~~	~~Safety~~	~~ALS~~
~~Nontransport-basic~~	~~X~~			
~~Nontransport-ALS~~	~~X~~			~~X~~
~~Ambulance-basic~~	~~X~~	~~X~~	~~X~~	
~~Ambulance-ALS~~	~~X~~	~~X~~	~~X~~	~~X~~
~~Air (rotor)-basic~~	~~X~~	~~X~~	~~X~~	
~~Air (rotor)-ALS~~	~~X~~	~~X~~	~~X~~	~~X~~
~~Air (fixed)-basic~~	~~X~~	~~X~~		
~~Air (fixed)-ALS~~	~~X~~	~~X~~		~~X~~

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.212 RECORDS AND REPORTS (1) through (4) remain as proposed.

(5) ~~As~~ Immediately or as soon as possible upon arrival at a receiving facility, but no later than 48 hours after the end of the patient transport, an ambulance service must provide a copy of the trip report to the hospital that receives the patient.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.221 MEDICAL CONTROL: ADVANCED LIFE SUPPORT

(1) An advanced life support service must have either:

(a) a two-way communications system, approved by the department, between the advanced life support service personnel and a 24-hour physician-staffed emergency department; or

~~(a)~~(b) a physician approved by the medical director.

(2) remains as proposed.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.316 PERSONNEL REQUIREMENTS: BASIC LIFE SUPPORT GROUND AMBULANCE SERVICE (1) A basic life support ground ambulance service must ensure that at least two of the following individuals are on board the ambulance when a patient is loaded or transported, with the proviso that having only two ~~first responders-ambulance~~ EMT-Fs with ambulance endorsements on a call is not allowed:

(a) a grandfathered person certified in advanced first aid;

~~(b) first responder-ambulance;~~

~~(c)~~(b) an EMT-basic equivalent; or

~~(d)~~(c) a physician.

(2) remains as proposed.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

6. The Department has thoroughly considered all commentary received. The comments received and the Department's response to each follow:

COMMENT #1: Deletion of the definition of "grandfathered nurse" would require grandfathered nurses to attend supplemental training in order to continue to provide pre-hospital services. This requirement would be unreasonable for nurses who have already been providing these services for 15 or more years. The supplemental training requirement would prevent the effected nurses from providing care in communities that are facing a shortage of pre-hospital personnel.

The Department's statement of reasonable necessity for ARM 37.104.101(26) does not cite any evidence that indicates a need for the elimination of the grandfather clause relating to the 50 registered nurses. We are aware of no evidence that patient care has been compromised by a grandfathered nurse. There is no provision in the proposed rules that would allow a service medical director to approve a grandfathered registered nurse to continue to provide emergency field care without supplemental training based upon the director's determination of training equivalency. Proposed ARM 37.104.101 clearly requires those nurses to complete supplemental training without exception.

We recommend amendment of the "grandfathered nurse" definition to a format similar to that in the "Grandfathered advanced first

aid" definition, or clear alternative language for those nurses who are already competent in their "knowledge and skill objectives comparable to the level of EMT training. . . ."

RESPONSE: The Department disagrees and has deleted the grandfathered nurse definition. We have clarified ARM 37.104.101(34) so that the service medical director, under his or her broad authority and responsibility for the medical aspects of emergency medical services (EMS) may individualize training for each nurse so it "complements their existing experience and education and results in knowledge and skill objectives comparable to the level of EMT training corresponding to the level at which the service is licensed". The Department has already received written authorization from the service medical director for each nurse added to service rosters since 1992. Therefore, the deletion of the grandfathered nurse definition will only require current grandfathered nurses to be authorized by the service medical director in a like manner to other nurses.

The rule does not require that grandfathered nurses attend the whole Department of Transportation (DoT) approved EMT course. This gives them latitude to supplement their knowledge base appropriately. Since the service medical director has complete discretion over what this training will be, the smallest EMS service has the ability to continue using nurses to supplement their ambulance crew. It requires only that nurses get education to the level that the ambulance service is licensed. If it is a basic life support (BLS) service, the level most likely to use nurses, there is no built-in barrier to service. Additionally, this will more clearly bring grandfathered nurses under the medical director's umbrella of responsibility. The Department intends that a service medical director will authorize qualified experienced nurses without any further training.

COMMENT #2: Content of the supplemental training course. What is the content of the supplemental training course? How will training be provided? By whom and where will it be conducted? What if a nurse already has the education and skills required to perform the job?

RESPONSE: The content, method, instructor, and location of supplemental training will be determined by the service medical director. The extent of the training, if any, will be determined individually based on the level at which the ambulance service is licensed and the nurse's training and experience. For more detail, please see the response to Comment #1.

COMMENT #3: The requirement of additional training for nurses conflicts with Board of Nursing jurisdiction.

RESPONSE: The Department respectfully disagrees. 50-6-323,

MCA, Powers and Duties of Department, requires the Department to prescribe and enforce rules for EMSs. Rules of the Department may include minimum licensing standards for each type and level of service, "including requirements for personnel" and other requirements necessary and appropriate to assure the quality, safety, and proper operation and administration of EMSs. The Department believes it is necessary to establish training standards for EMS personnel. The supplemental training requirements for grandfathered nurses are no different from those of other EMS personnel providing pre-hospital services.

COMMENT #4: Why are grandfathered nurses different from "Grandfathered advanced first aid"? The grandfather clause relating to American Red Cross certified providers was preserved and carried forward without explanation for the disparate treatment.

RESPONSE: The Department's intent in deleting the grandfathered nurse definition is to bring grandfathered nurses under the oversight of the service medical director, a condition already met by the "grandfathered first aid" level of care providers (GFAs). The Department does not expect elimination of the grandfathered nurse category to present any hardship to services. Conversely, elimination of GFAs would require that they attend an EMT course and be licensed as EMTs. The Department encourages all GFAs to do this voluntarily so that the GFA definition can also be eliminated in a future revision.

COMMENT #5: Forty-eight hours to provide a trip report to the receiving hospital is far too long. The proposed amendment to ARM 37.104.212 could severely hamper the receiving facility's and personnel's ability to have the appropriate information needed to stabilize and transport the patient to a higher level of care, if necessary. Since the majority of Montana hospitals are rural, and they all transport major trauma cases, it is crucial for them to have accurate and timely information about what services were provided, and when, so that they may deliver accurate and timely treatment. A delay of nearly 48 hours could potentially jeopardize patient safety.

We understand the difficulty of back-to-back calls, but paperwork is often the infrastructure of safe patient care. We recommend deleting the proposed new language.

RESPONSE: The Department agrees that patient reports are essential to continuity of care and should be provided to the receiving hospital before the EMS personnel leave the receiving facility. In order to accommodate situations in which services may have multiple calls, current rules only require trip reports to be completed "as soon as practicable". This has been interpreted very broadly at times and is unenforceable. While 48 hours is not ideal, rules are designed to set a minimum standard and this change reflects a minimum standard that is at least enforceable. Therefore, the Department has further

strengthened this concept in the final rules.

The Department will be deploying a new web-based electronic data collection system in the fall of 2005. We plan to then use educational and quality improvement as the means to enable services to meet a higher standard. This entire rule on records and reports will be further revised as needed in the future.

COMMENT #6: A service medical director is authorized under ARM 37.104.221(1) to approve physicians as online medical control. If so, the service medical director would be reviewing the qualifications of a medical doctor, a process that implies a judgment relating to the qualifications and appropriateness of the physician. Where the service medical director is a physican assistant (PA), such approval process is counter intuitive.

RESPONSE: While ARM 37.104.218(3) does provide that a service medical director can be a PA who can approve physicians as online medical control, the decision is subject to the approval and oversight of the PA's supervising physician (ARM 24.156.116).

COMMENT #7: The proposed inclusion of "physician assistant" in ARM 37.104.218, "Medical Control: Service Medical Director" is unnecessary because PA orders are as if they come from the physician.

RESPONSE: The proposed definition follows the definition of a service medical director under the BOME rule. It specifically lists both the physician and PA. The Department has listed both as allowable service medical directors in order to prevent any confusion by licensed services.

COMMENT #8: We question the legality of allowing an EMT to perform advanced life support (ALS) within a service that is only licensed to the basic life support (BLS) level, but is authorized to provide limited ALS.

RESPONSE: The Department currently licenses all services that provide ALS (part-time and full-time) at the ALS level. Services that cannot provide ALS level care 24/7 are still held to ALS licensing standards even if the limitation on ALS care was due to the limited availability of ALS EMTs locally. Limited ALS and a full-time ALS license would blur the standard by which a service will be judged if there is a complaint.

The Department finds that licensing a limited ALS service at a (BLS) level, but authorizing ALS when sufficient personnel are available is a better policy. A BLS service with ALS authorization will be first judged on whether they provided BLS standard care. Then, if the complaint is about ALS care, the EMT that provided that care will be judged as to whether he provided standard ALS care. The whole service is not at risk this way and it is much clearer to us, the service, and the

public what level of care the service is able to provide. The process of licensing a service at a BLS level, but authorizing them to provide limited ALS mirrors the licensing process of the Board of Medical Examiners.

COMMENT #9: The process by which a basic life support service is "authorized" to operate beyond the scope of its department-issued license and to operate instead under the licenses of individual EMTs issued by the Board of Medical Examiners (BOME) is not contained in substantive rules but rather, is identified only in the nonsubstantive definition of the term "authorization" in ARM 37.104.101. The jurisdictional and other problems created by that process might be avoided by having a limited advanced life support level of EMS licensure. Attempting to piggyback an emergency medical service's level of authorized service onto the individual EMT's licensure and endorsement is of questionable legality and muddies the jurisdictional waters.

RESPONSE: The Department agrees, in part, and has moved the substantive provision to a rule, Rule II (ARM 37.104.109). The process of licensing a service at a BLS level, but authorizing them to provide limited ALS mirrors the licensing process of the Board of Medical Examiners. Under BOME rules, an EMT is licensed at a basic life support level, but receives endorsements to provide limited ALS. For further information, please see the response to Comment #7.

COMMENT #10: All levels of endorsements above the basic EMT level should be advanced life support and the proposed exception for the EMT-B 2 endorsement should be deleted.

RESPONSE: The Department agrees and has changed the rule accordingly.

COMMENT #11: The definition of "standard of care" should require emergency medical personnel to provide care that conforms to the general standards of care promulgated by the BOME.

RESPONSE: The Department agrees and has changed the rule accordingly. Additionally, the adoption of this definition reinforces the need to delete the definition "grandfathered nurse" to bring grandfathered nurses under the explicit oversight of service medical directors.

COMMENT #12: EMT level of care limitations. We recommend alternate language for Rule IX (ARM 37.104.330):

> (1) With the exception of a physician or the circumstances described in ARM 37.104.335(3), individual personnel shall not provide care higher than the level and type for which the EMS is licensed. The service must be authorized to operate at the

highest level they plan to allow individuals to provide care."

RESPONSE: The Department agrees and has changed the rule accordingly.

COMMENT #13: The definition for a defibrillator in ARM 37.104.101 should be eliminated. The unit described does not exist and the definition limits the type of defibrillator that may be used.

RESPONSE: The Department agrees and has changed the rule accordingly.

COMMENT #14: The term "first-responder-ambulance" should be eliminated and replaced with "first-responder with an ambulance endorsement".

RESPONSE: The Department agrees and has changed the rule accordingly. The change furthers the Department's goal of making these rules consistent with BOME rules.

COMMENT #15: The term "physician assistant-certified" is no longer used and should be "physician assistant".

RESPONSE: The Department agrees and has changed the rule accordingly.

COMMENT #16: It should be made very clear in ARM 37.104.316 that the ultimate authorization for EMS function should be a physician.

RESPONSE: The purpose of this rule is to set a minimum standard for the personnel on a BLS ambulance. A service medical director's powers and duties are already clearly defined in ARM 37.104.101. Furthermore, the Department's definition of "online medical control" refers to the applicable BOME rule. The Department believes no further clarification is needed.

COMMENT #17: Equipment kits for each endorsement level of care should be defined within ARM 37.104.101(3) as "Advanced life support kit".

RESPONSE: The Department disagrees. This would not be an acceptable or easily enforceable provision. Under current rules, there are only two levels of advanced level EMT certification (EMT-I and EMT-P). Under the proposed rules, 14 additional endorsement levels of care were added above EMT-basic. While it acknowledges that minimum supplies and equipment for each of these levels could be defined, the Department would rather continue to allow a service medical director to apply for an exception to any of the minimum requirements. Consequently, there could be as many variations in equipment and supplies as there are services and there would

be no recognized minimum standard. The tracking and enforcement of these various levels would be problematic for the Department and would do nothing to improve the safety or care of patients.

COMMENT #18: Online physician control. We recommend the following alternative language for ARM 37.104.221:

> 37.104.221 MEDICAL CONTROL: ADVANCED LIFE SUPPORT. An advanced life support service must have either:
>
> (a) a two-way communications system, approved by the department, between the advanced life support service personnel and a 24-hour physician-staffed emergency department; or
>
> (b) a physician approved by the medical director.

RESPONSE: The Department agrees and has changed the rule accordingly. No change in the substantive content of the proposed rule is intended.

COMMENT #19: We support the proposed change to ARM 37.104.316(1) pertaining to the BLS ground ambulance service personnel roster. Must the two on board medical personnel necessarily be on the transport services' roster?

RESPONSE: The proposed change provides that it is allowable for a service to respond to a scene with only one of two required personnel on board. This allows for some flexibility under special circumstances, for example, when the second provider responds directly to the scene because it is closer or quicker than responding to the ambulance directly. This amendment does not change the current requirement that the two required providers, who must be on the service roster, be on board the ambulance when a patient is loaded or transported.

COMMENT #20: Would the ALS medical control rules apply when an authorized BLS service is supplying a higher level of care as provided in ARM 37.104.316(2) pertaining to BLS ground ambulance service personnel?

RESPONSE: This rule compliments other provisions of these rules which allow a BLS licensed service to provide limited ALS care through an authorization from the Department. As such, all services providing ALS care must have a service medical director.

COMMENT #21: We are concerned about the potential confusion that a BLS licensed service with an authorization for ALS may present to billing entities.

RESPONSE: In order to avoid any problems or issues, the Department met with representatives of Medicare and Medicaid several months ago to explain the concept of endorsement levels

of care. Neither agency anticipated any billing issues as a result of the new levels. Also, the Department has been issuing waivers to allow services to provide and bill for these endorsement levels for several months now. The Department is not aware of any related billing complaints or issues.

COMMENT #22: We are concerned about the similarity between a BLS service that occasionally provides advanced care and an ALS licensed service that provides advanced care 24 hours a day, seven days a week (24/7). It is very important the public understands there are two types of services available, that they render two types of care and that expectations should be different for each of them.

RESPONSE: The Department believes that, with the advertising restrictions in Rule II (ARM 37.104.109), the public will be protected from misleading claims. It should be noted that the BOME rules designate all skills above BLS as ALS. The emphasis of this rule revision is the adoption of the endorsement levels of care. For further information, please refer to the response to Comment #7. The Department acknowledges that this issue may merit further review. A rule revision process will begin as soon as this set of rule revisions is adopted. The Department will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #23: We are concerned that the advertising restrictions Rule II (ARM 37.104.109) would allow BLS services with an authorization to provide limited ALS or an endorsement level of care to misrepresent their capabilities to the public.

RESPONSE: The Department believes Rule II (ARM 37.104.109) adequately addresses this concern. Additionally, the service plan required under that rule will clarify to the Department, the public, and others what level of care the service is capable of providing.

COMMENT #24: Rule VII(1)(b) (ARM 37.104.108) should be revised to more clearly state how EMS services may or may not advertise their level of licensure.

RESPONSE: The Department disagrees. The language of Rule VII (ARM 37.104.108) is intended to allow a service to advertise only at a level for which it is licensed. Currently, any service that provides any level of advanced life support, full-time or part-time, is licensed at an ALS level and can advertise that it provides ALS. Under these rules, only services that can provide ALS services 24/7 will be licensed as ALS and allowed to advertise as ALS services. The Department acknowledges there are still matters to be discussed and worked out. Therefore, the Department will present the comment to the EMS System Task Force and the EMS community in the next revision.

COMMENT #25: Rule II(2) (ARM 37.104.109) should be revised to

require EMS services providing limited ALS services or endorsements to have an agreement with a licensed ambulance service of equal or higher level of care that provides transportation and patient care 24/7.

RESPONSE: The Department disagrees. While this may increase the level of patient care in and around the major cities of Montana, it would encumber limited ALS care in rural areas that are not reasonably close to any of the 24/7 services. The coordination of ambulance services is beyond the scope of this rule revision. The Department will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #26: The Department needs to define what should be contained in a service plan and what constitutes approval of a plan described in Rule II(2) (ARM 37.104.109) to allow a BLS service with endorsements to provide advanced care less than 24/7. Also, a recommendation was made to require all EMS services providing limited ALS services or endorsements to have an agreement in place with a licensed ambulance which provides ALS 24/7.

RESPONSE: Under ARM 37.104.106, services are required to apply for a license on forms specified by the Department. The service plan will be an additional form on the service license application. According to the form, the service will be asked to provide information about what endorsements will be available, where they will be available, and how often they anticipate the services to be available. Since the service medical director is ultimately responsible for the oversight of endorsement compliance, the Department does not anticipate that there will be a reason to deny the license as long as the service plan is complete. Complaints about endorsement care are under BOME jurisdiction. The Department will become involved when the service as a whole is not complying with the service plan and patient care is compromised.

COMMENT #27: The current structure of rules should be changed to provide for commercial and noncommercial licenses. We recommend that commercial licenses be granted only to those services that provide ALS 24/7, 52 weeks a year and that all noncommercial services would have to have an agreement with a commercial service in order to provide services.

RESPONSE: Such a revision would require a comprehensive restructuring of the entire EMS subchapter. It would further delay the adoption of rules for endorsement levels of care that are already ongoing. The Department acknowledges that the licensing structure may merit further review. The Department will present this issue to the EMS System Task Force and the EMS community in the next revision. For a more detailed discussion of agreements between services please see the response to Comment #23.

COMMENT #28: We recommend that Rule III (37.104.111) be expanded to require any agency or organization that provides medical care to license as an EMS service.

RESPONSE: The Department disagrees. Implementing this suggestion would unnecessarily expand licensing requirements, adding expense and delay to the licensing process. It would affect hundreds of fire departments, law enforcement agencies and other organizations. Such a revision would require a comprehensive revision of the licensing rules. It would delay the adoption of rules for endorsement levels of care under EMS service licenses. The Department acknowledges that this issue may merit further review. The Department will present it to the EMS System Task Force and the EMS community in the next revision.

COMMENT #29: We recommend that level of care be solely a responsibility of the service medical director. There should be no relationship between level of care and the service license. Additionally, authorized levels of care should be dependent on the ability to deliver endorsements "consistently" rather than "occasionally".

RESPONSE: The Department disagrees. 50-6-306, MCA provides that a person may not operate an emergency medical service without first obtaining a license from the Department. A separate license is required for each type and level of service. Under 50-6-301, MCA it is the Department's responsibility to establish minimum uniform standards for the operation of emergency medical services. The control, inspection, and regulation of persons providing emergency medical services is necessary to prevent or eliminate improper care that may endanger the health of the public. It would not be appropriate for the Department to delegate that responsibility to service medical directors.

COMMENT #30: No organization should be able to hold an ALS license unless it offers the services 24/7 and has paramedics employed to provide ALS services consistently. Services that offer ALS skills occasionally should not be considered or licensed as ALS. As an organization that maintains 24/7 coverage, we need some sort of assistance to maintain this level of services. They come at great cost to our organization.

The distinction of a paramedic service is lost under the definition of a "Advanced Life Support Service". It portrays EMT-B and EMT-I services with endorsements as the equivalent of a paramedic service. Although the endorsement program has greatly improved basic care, it still falls far short of ALS. We recommend that levels of care be described as Basic Care, Advanced Basic Care, Advanced Care, and Advanced Life Support.

RESPONSE: The Department declines to designate four levels of care in this rule revision. However, it acknowledges the

concern of ALS services that have made a considerable commitment to providing consistent paramedic care to their communities. Alternate terms may help clarify levels of care to the Department, the services and the public, but such a revision would require a comprehensive revision of the licensing rules. The time necessary to do so would delay the adoption of endorsement levels of care under EMS service licensure. The Department will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #31: We oppose the deletion of the requirement that all licensed ambulance vehicles have a sticker under ARM 37.104.101(27) "Permit". It is important that law enforcement officers be able to visually determine that a vehicle is a bona fide ambulance.

RESPONSE: The Department agrees there are compelling reasons to retain the requirement for a sticker and to implement a program to provide visible permits for ambulances. Therefore, the Department has retained the existing language of this definition.

COMMENT #32: "Grandfathered advanced first aid" is not a recognized level of care. Therefore, it is not a level of care that can be governed by the Department or the BOME.

RESPONSE: The Department agrees that grandfathered advanced first aid certification should be raised to an EMT level. However, such a revision would require a broad discussion with the BOME and is beyond the scope of these rule changes. It would delay the adoption of endorsement levels of care under EMS service licensure. Therefore, the Department will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #33: We oppose the requirement that a service plan be submitted for a "commercially" licensed organization.

RESPONSE: These rules only require a service plan to be submitted by a BLS service applying for authorization to provide ALS on a less than 24/7 basis. There is no requirement for a service that provides advanced life support on a 24/7 basis to submit a service plan.

COMMENT #34: The Equipment kit table, Table I under ARM 37.10.203, should be deleted because it is confusing and unnecessary.

RESPONSE: The Department agrees and has changed the rule accordingly. Elimination of several of the kits referred to in the table was proposed in these rules and the Department has eliminated the table to make the rule simpler and easier to understand. The Department has deleted references to Table I in these rules.

COMMENT #35: We recommend that ARM 37.104.208, "Sanitation" should be limited to a general reference to an OSHA required exposure plan.

RESPONSE: The Department disagrees, at least for purposes of this rule revision. The Department acknowledges that these rules require minimal guidelines that may or may not be specifically addressed in OSHA regulations. Further discussions to adequately address this issue would delay the adoption of endorsement levels of care under EMS service licensure. Therefore, the Department will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #36: ARM 37.104.213(1)(a) requiring current certificates and other evidence of legal authorization should only refer to "licensed EMTs".

RESPONSE: This subsection also covers nurses functioning on an EMS service. Therefore, the Department disagrees. Narrowing the subsection to licensed EMTs is not in the best interest of patients.

COMMENT #37: We recommend that the language of ARM 37.104.213, "Personnel requirements" be amended to read: "the person certified at the corresponding level must attend the patient when the patient's condition and treatment warrants it". As proposed, the rule limits the ability of lower level providers to obtain critical patient contact and on-the-job training to expand their education and experience.

RESPONSE: The Department believes the suggested language is unnecessary. The applicable rule language states: ". . . when providing care at an advanced life support level, the person certified at the corresponding level must attend the patient". These rules are not intended to limit patient contact by lower level providers.

COMMENT #38: ARM 37.104.306 should specify a minimum size for the required "ambulance" emblems on a ground ambulance or the definition is meaningless and should be deleted.

RESPONSE: The Department disagrees. No minimum size has ever been specified in the rules for "ambulance" emblems. Yet the Department is not aware of any service that has ignored the intent of this rule by minimizing these emblems because they help to assure the safety of the crews, the patients, and the public. There is no need to further complicate the rule.

COMMENT #39: ARM 37.104.306, "Ambulance Specifications: Ground Ambulances" should require all ambulances to undergo an annual safety inspection.

RESPONSE: The emphasis of this rule revision is the adoption of the endorsement levels of care. The Department acknowledges

that ambulance safety inspections may merit further review. It will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #40: There should be increased emphasis on regulation of aero-medical systems.

RESPONSE: As explained in the response to Comment #21, the emphasis of this rule revision is the adoption of the endorsement levels of care. The Department acknowledges that regulation of aeromedical systems may merit further review. The Department will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #41: The term "advanced life support EMT" should be changed in ARM 37.104.329 to "advanced life support paramedic". Only these advanced life support paramedics are qualified to provide air ambulance advanced life support.

RESPONSE: The Department disagrees. The discussion of whether these rules should require only advanced life support paramedics in air ambulances would delay the adoption of endorsement levels of care. The Department acknowledges that this may merit further review in a future rule revision process and will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #42: The Department should regulate air ambulance service response to 9-1-1 emergency calls.

RESPONSE: The Department disagrees, at least for purposes of this revision. While the regulation of air ambulance response to 9-1-1 calls in a tiered response system may merit further review, such a discussion would delay the adoption of endorsement levels of care. The Department will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #43: The Department should adopt different minimum staffing patterns for volunteer and full-time services. Higher standards are appropriate for full-time services. Labeling the types of services differently would enable the public to more clearly understand the level of care that each service provides.

RESPONSE: The Department disagrees. The Department acknowledges that further discussion of staffing patterns and requirements for volunteer and full-time services may be merited. However, such a discussion would delay the adoption of endorsement levels of care. The Department will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #44: The rules should take into account the different natures of commercial, noncommercial and nonemergency types of

services.

RESPONSE: The Department disagrees. There may be merit to further rule revisions to accommodate other types of service licenses. Such a discussion would delay the adoption of endorsement levels of care. The Department will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #45: The rules should be revised to accommodate additional license requirements for sanitation and OSHA safety standards. The Department should adopt the national accreditation standards.

RESPONSE: The Department disagrees. There may be merit in further discussions about additional service regulation and accreditation. Such a discussion would delay the adoption of endorsement levels of care. The Department will present this issue to the EMS System Task Force and the EMS community in the next revision.

COMMENT #46: The Department should adopt rules to address the inspection process. Regular service inspections should be conducted.

RESPONSE: The Department currently inspects all new services and all new ambulances. Also, the Department currently conducts regular, random inspections of all services upon renewal. The Department agrees that regular service inspections have merit. It intends to revise the inspection process to a quality improvement-based method that will better assure that patient care is optimal.

COMMENT #47: Ambulance equipment: splints. The definition for rigid splints under Rule V(1)(g) and (h) (ARM 37.104.206) should be expanded to allow air and vacuum splints as well.

RESPONSE: The Department disagrees. The Department intends the term "rigid splints" to include any material or device which effectively splints a fractured extremity. Air and vacuum splints would fit the definition. Therefore, they need not be specifically listed.

COMMENT #48: Several of the proposed rules and amendments are contrary to the rules and requirements of the National Registry of Emergency Medical Technicians (NREMT). Since Montana is a nationally registered state, it must follow those requirements.

RESPONSE: The Department disagrees that these rules conflict with NREMT standards. The purpose of these rule revisions is to harmonize emergency service licensing requirements with BOME rules.

COMMENT #49: The proposed rules equate BLS with EMT-

Intermediate care. They are not the same thing.

RESPONSE: The Department agrees that BLS as contemplated in these rules is not equivalent to EMT-Intermediate care in BOME rules. These rules designate all endorsement levels of care above BLS, including EMT-Intermediate, as Advanced Life Support. For further discussion, please see the response to Comment #8.

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Rule Reviewer	Director, Public Health and Human Services

Certified to the Secretary of State December 12, 2005.